

Patients' and clinicians' experiences of consultations in primary care for sleep problems and insomnia: a focus group study

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ABSTRACT

Background

Insomnia affects around one-third of adults in the UK. Many sufferers seek help from primary care.

Aim

To explore patients' and primary care practitioners' expectations, experiences, and outcomes of consultations for sleep difficulties, as a basis for improving the treatment of insomnia in primary care.

Design of study

A qualitative phenomenological approach.

Method

Separate focus groups for GPs and nurse prescribers and patients recruited from eight general practices that were in a quality improvement collaborative. Constant comparative analysis was used.

Results

Emergent themes from 14 focus groups comparing participating patients ($n = 30$) and practitioners ($n = 15$), provided insights on presentation, beliefs, expectations, and management of sleep problems. Patients initially tried to resolve insomnia themselves; consulting was often a last resort. Patients felt they needed to convince practitioners that their sleep difficulties were serious. They described insomnia in terms of the impact it was having on their life, whereas clinicians tended to focus on underlying causes. By the time patients consulted, many expected a prescription. Clinicians often assumed this was what patients wanted, and felt this would hamper patients' ability to take non-drug treatments seriously. Clinicians expected patients who were already on sleeping tablets to be resistant to stopping them, whereas patients were often open to alternatives.

Conclusion

Better management of insomnia should take into account the perceptions and interactions of patients and practitioners. Practitioners need to empathise, listen, elicit patients' beliefs and expectations, assess sleep better, and offer a range of treatments, including cognitive and behavioural therapies, tailored to individual needs. Practitioner education should incorporate understanding of patients' decision-making processes, the clinicians' role during the consultation, and how to negotiate and deliver strategies for resolving sleep problems.

Keywords

attitudes; beliefs; family physician; focus groups; insomnia; nurse practitioner; primary care; qualitative research; therapeutics.

INTRODUCTION

Insomnia is common, affecting one-third of adults in the UK¹ and North America.² It is costly in terms of work absence or dysfunction, impaired health-related quality of life, and health service use.³ In over one-third of new patients, symptoms will become recurrent or chronic.^{4,5} Insomnia is often comorbid, and is linked to anxiety and depression,⁶ physical problems, and chronic pain.⁷ Assessment is important, but treatment of insomnia itself will often lead to improvements in functioning and quality of life.⁷

Up to a half of patients with insomnia seek medical help from primary care, and in the UK, with a typical consultation lasting 10 minutes, patients usually receive a sleep hygiene leaflet and/or are

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prescribed a hypnotic.⁸⁻¹⁰ There is a recognised need to improve the management of sleep problems through education of evidence-based treatment of insomnia for clinicians and patients, using psychosocial interventions, including cognitive behavioural therapy for insomnia.^{11,12}

To provide better management and improve the user experience of care of sleep problems,¹³ it is necessary to understand patients' and clinicians' beliefs and expectations.^{14,15} There have been a few small-scale interview studies of sleep management involving clinical specialists¹⁶ and patients,¹⁷ and one study of females with insomnia and their GPs,¹⁸ but there remains limited evidence on how the primary care consultation for sleep problems might be improved, or how sleep assessment and psychosocial interventions could be introduced.

This focus group study aimed to explore experiences and expectations of patients and primary care practitioners in consultations for insomnia, and to improve the treatment of insomnia by exploring aspects of primary care consultations that are conducive to, or a barrier to, positive patient and clinician experiences. The study formed part of the modelling for a complex intervention to manage sleep problems in primary care.¹⁹

METHOD

Study design

A qualitative phenomenological approach was adopted, using separate focus groups for practitioners and patients,²⁰ to explore and compare the breadth and depth of experiences, beliefs, and perceptions associated with consultations for sleep problems. The researchers were interested in the lived experience of the primary care consultation for sleep difficulties, what happens during such consultations, and the meaning for those involved.

Sample

Volunteer patients (who had consulted with insomnia during the previous 6 months) and practitioners (GPs and nurse prescribers) were selected from eight general practices taking part in a quality improvement collaborative. Patients, excluding those with terminal illness or addiction to illegal substances, were recruited using postal invitations from practices, waiting room posters, and newspaper advertisements.²¹ Demographic information was collected to determine that participants were of different sex, age, work, and socioeconomic status.

Interviews

Three or more focus groups each of patients and clinicians were planned, including up to eight in each group,²² with more if needed for data

How this fits in

The seriousness of insomnia is recognised in terms of chronicity, impact, and risk for ill health. It affects around one-third of adults in the UK; many of whom turn to primary care after having tried self-help unsuccessfully, expecting hypnotics. This study identifies barriers to better recognition and treatment of insomnia including inadequate training, lack of time, poor knowledge of treatment options, and uncertainty about evidence. Practitioners often assume that patients expect drug treatment even when patients might prefer self-care. This misunderstanding is also likely to be a barrier to non-drug options.

saturation. Meetings were held during 2008 in public venues. Semi-structured scripted question schedules were used (Appendices 1 and 2). Field notes were made and group proceedings were tape-recorded and transcribed verbatim. Neither the facilitator nor co-facilitators was a clinician.

Ethical approval

Written informed consent was obtained from participants. In case of patients becoming distressed or requiring additional support as a result of the interview, access to a psychologist was offered via the patients' GPs.

Analysis

Interview data were managed using MAXQDA2007. Constant comparative analysis was used,²³ employing a coding template agreed by three authors for the subsequent transcript analysis. A priori themes implicit in the focus group schedule were not used in the template. Separate analyses of practitioner and patient data were undertaken. The final analysis combined the two datasets to compare and contrast experiences.

RESULTS

There were 14 focus groups in all. Eleven patient focus groups (Groups A to K, with 2-5 participants in each) involved 30 service users: 11 males and 19 females, aged between 25 and 70 years, from a variety of socioeconomic backgrounds and varying work status. They had experienced sleep problems for a few months to many years, most having tried a variety of remedies, with 24 taking hypnotics (prescribed or over-the-counter) at the time of the study. Three of the 14 focus groups (Groups 1 to 3, with three, five, and seven participants respectively) involved 15 clinicians: 11 GPs and four nurse prescribers, seven males, and eight females, from a variety of settings, including urban, semi-rural and rural, as well as prescribing and dispensing group practices. Practitioners ranged from recently qualified GPs and nurse prescribers to those with over 25 years' experience. Recruitment to the focus

groups continued until data saturation was achieved.

The findings are summarised next in four main categories: explanations for consulting, expectations within the consultation, influences on sleep management, and improving the consultation for sleep problems (full details of coding can be found in Appendices 3 and 4).

Patients' reasons and clinicians' explanations for sleep consultations

Patients perceived a need to convince practitioners of the seriousness of sleep difficulties. Although patients felt that GPs recognised the impact of sleeplessness on their lives, the psychosocial effects were often not discussed. This contrasted with the importance of the impact that lack of sleep had on their lives, which was the justification for seeking a consultation:

'I said to my doctor recently, "When I die ... I don't want breast cancer on my death certificate, I don't want emphysema, I want insomnia because I am sure that's at the root of all my problems".' (Group E; Patient 2 [GE; P2])

'I'm not so bad now but some days I'm really shaky so the doctor can see I'm a nervous wreck.' (GH; P5)

'I was having marriage problems because this thing of not sleeping so I went for help really to help me to sleep ...' (GF; P5)

'Take for instance Friday night, I went to bed at 10.30 pm; by 11.15 pm I was wide awake, I went back to bed at 3.30 am then I didn't really want to go to bed, but I do know that if I don't go to sleep I am going to make myself ill with it.' (GC; P2)

Clinicians acknowledged the adverse impact of sleep problems on patients' lives and perceived this to be the justification for consulting. In some cases, clinicians felt that patients presented for reassurance that their changing sleep patterns were 'normal'. In other instances, some clinicians felt sleep problems were presented to make them take patients' concerns more seriously:

'I sometimes feel it is used by patients as a qualifier you know if they are having a discussion with you about their knee and they don't feel you are taking it serious enough, they will throw in the fact that it is keeping them

awake — as a sort of extra bit of punishment really.' (Group 3; Clinician 4 [G3; C4])

'Can't carry on with work ... too exhausted, a relationship problem, lots of things.' (G1; C2)

'I think sometimes it is also a more socially acceptable presentation because what they are really saying is that my quality of life has gone downhill and that there are a lot of other issues that come to the surface and are packaged as a sleep problem.' (G3; C5)

Patients and clinicians recognised that sleep difficulties were related to physical, mental health, lifestyle, or psychosocial issues and sometimes environmental factors:

'I wasn't actually working and therefore wasn't expending the energy.' (GK; P1)

'I think a lot of it is because I'm so tired, that is what causes the depression.' (GF; P4)

'I will stay awake until I hear him come home ...' (GC; P1)

'I feel there is something in the environment causing this and I asked around, my GP and all sorts of specialists, but none of them seem to have met anyone with this particular problem.' (GB; P2)

Clinicians recognised that insomnia often has multiple causes. An important difference was that clinicians spoke about sleep difficulties in terms of causes and precipitants, whereas patients talked about the disabling impact of lack of sleep on their lives and health. Clinicians also tended to attribute insomnia to patients being depressed, while patients considered lack of sleep to be the cause of feeling depressed.

Triggers of help-seeking. Patients had often coped with sleep problems for considerable periods of time before consulting. Consultation was often triggered by significant life events or pressure from family and friends (social networks). By the time patients consulted with a GP or nurse prescriber, they had begun to see their problem as needing medical treatment rather than part of the range of normal human experience. Also, to consult a GP, some patients (whether consciously or subconsciously) felt that they had to express their sleep problem as a medical issue as a justification for the consultation:

'Where we had been living was in a stressful situation, it was a middle flat, the neighbours were drug addicts and this caused a lot of problems for us. When we moved out ... the noise was no longer there but still the sleeplessness was a problem.' (GK; P1)

'I always think that if it was something I had on my mind I would be aware of that, and I probably wouldn't be going to a doctor to have it sorted I would address it myself.' (GA; P2)

Practitioners also attributed sleep difficulties to complex life events and adversity, understood that patients' sleep problems were psychological, social, or relational in nature, and appreciated that a decision to consult was sometimes suggested by social networks of family or friends.

Patients' and clinicians' expectations within the consultation

Practitioners expected patients to have tried self-help methods of improving sleep before making their appointment:

'I always find the exercise one quite good because they usually had twigged on and often didn't drink too much tea or coffee, but the exercise one was the one you could get most of them on.' (G3; C8)

In contrast, patients often spoke of having resorted to exhaustive and expensive but ultimately ineffective self-help to try to resolve the problem themselves.

Patients felt that self-help alternatives to sleeping tablets they had tried may have 'worked' in the short term but the effect 'wore off'. On the basis of this experience, some also anticipated that a similar pattern would be repeated with other non-drug-based interventions:

'There was nothing really they could advise, if we'd tried [a sleep aid like] Nytol, the milky drinks at night, going to bed at a certain time and getting up a certain time all that sort of thing, that's about all they discussed, and we'd already tried those.' (GF; P5)

Wants. Practitioners felt that many patients wanted drugs, but they also acknowledged that some patients disliked drugs or feared medication because of worries about addiction:

'It's actually quite staggering the amount of people who come asking for sleeping tablets

which they know are addictive and they still want the sleeping tablets.' (G1; C3)

'If we know the patient is anti-medication then we obviously go through the other options.' (G3; C9)

Patients also consulted expecting that drugs or other therapies would relieve insomnia and concomitant problems of coping. Some patients wanted a prescription but other patients disliked the idea of sleeping tablets and sought non-drug treatments:

'You are hoping for some lovely panacea tablet or medicine when you go in there and think, "Well I've got an appointment they are bound to give me a bit of help".' (GD; P2)

'... not just give me a sleeping tablet, but give me some positive feedback that has worked for other people.' (GD; P3)

Resistance. Practitioners expected resistance from patients to being taken off their usual sleep medication or to the suggestion of non-drug treatments. They thought that patients would resist the sleep hygiene advice and not take it seriously. However, prescribers also revealed that by not prescribing they might be perceived as not taking the complaint seriously:

'... you knew you had a bit of a battle on your hands to not prescribe sleeping tablets and get a happy patient walking out the door.' (G3; C7)

Patients also expected resistance from prescribers who might not readily accede to their requests for a prescription, but some were resistant to taking drugs and wanted an alternative:

'My doctor took a lot of persuading to put me back on them [temazepam]. I said, "Look at my age ... what the hell does it matter I've been addicted for 20 years I might die tomorrow" ... so, so he let me have them.' (GE; P2)

Influences on sleep management

Clinicians and patients described prescriptions for hypnotics as a 'quick fix' and justified this approach by claiming that they (the patients) had already tried alternatives. They argued that prescribing was legitimate in the short term, or appropriate for adverse life events such as bereavement.

Although many patients perceived that drugs did not afford a long-term solution for sleep problems,

some indicated that drugs had been helpful, at least in the short term. If there was a mismatch in expectation, whereby the patient was hoping for a prescription for drugs but the GP did not prescribe, alternative approaches were viewed as ineffective. If the situation was reversed the patient accepted the prescription with reluctance. Although they did not want to be seen as asking for the drugs, patients legitimised and justified their desire for drugs by highlighting that it was their doctors' decision:

'... if someone came in and said I couldn't sleep, I thought "Great take this" ...' (GD; C4)

'... often I would have tried to persuade them to try these various different things but of course they would say, "Tried that doctor, tried that doctor, doesn't work".' (GD; C3)

'... no doubt you see people who have recently been bereaved or have lost their job and they are looking for a short-term solution and I think that we would probably deal with that quite differently to someone who comes and says they have never slept very well, it's been a long-term problem.' (GD; C3)

Some patients welcomed a prescription they could use as needed. They found it empowering that a practitioner trusted them to take hypnotics appropriately. Others used the system to gain drugs as a fall-back for the future. Some patients, having tried different drugs, wanted a choice. Others emphasised that they had not wanted sleeping tablets. Many patients preferred not to resort to hypnotic drugs because of fear of side-effects, especially addiction or dependence, and lack of effect. Some found drugs unhelpful or counterproductive. Others misused drugs. Practitioners often became aware of this during the consultation:

'... but we go to the doctors and we already know what's wrong with us and we already know what we want prescribing.' (GK; P2)

'They know that I am a sensible sort of person with a sensible sort of attitude; they continue with the prescription and I continue using it when I need to and that suits me fine.' (GI; P4)

'Certain drugs don't work for me. Zopiclone I've had, but they still insist on trying to prescribe me with it rather than give me another drug like the more powerful drugs, benzodiazepines. They are very reluctant obviously because of the

overdose risk etcetera, but they are the only ones that work for me.' (GA; P2)

'I'm obviously addicted to them; I don't want to come off them straight away. I'm stock-piling and every time I go I get more tablets, because I need to know if he stops them I've got some in reserve for emergencies.' (GH; P5)

'I was fed up with not being able to sleep, and I was tired of trying to sleep and doing all different things to try to sleep and I thought if I go there perhaps he can give me something to help me make me sleep but when he said that the tablets were addictive I didn't want to take the tablets. So I went another avenue, I went to the hypnotist.' (GE; P3)

'Recently my doctor said I'm going to give something that what you'd call a "Mickey Finn" knock-out drops; he said one spoonful and 2 hours later I took another and another. The next night I drank two-thirds of the bottle.' (GE; P2)

Alternatives to drugs. Many patients had tried a range of alternatives to prescribed drugs for sleep problems for considerable periods before consulting. These included exercise, relaxation, over-the-counter drugs, herbal and miscellaneous remedies, or complementary therapies. Some had even read about cognitive behavioural therapy. Some implied that they had initially preferred not to seek prescription medication, which they felt was a last resort.

Many patients described, despite not initially seeking medication, shifting their stance so that they were hoping to be given a prescription by the time they sought advice. Clinicians expressed how their awareness of this expectation influenced the choices they offered. Some patients presented their expectation for drugs strongly to the GP, which had considerable influence on the decision-making process. Many patients found alternatives ineffective, or that the effect wore off:

'My wife says go out and play more golf or whatever.' (GA; P2)

'We all had to lie on the floor and you know from the tip of your toes to your head you are completely relaxed ... and some of these people were practically asleep but it just had no effect on me whatsoever. I think I must be just one of those people where these kinds of things don't work.' (GA; P3)

'From the chemists, like Sleepzeze, all those sorts of things and they don't do anything. I'm a great reader of anything, and if anyone suggests anything I'll go and buy that book.' (GK; P2)

'I have spent £500 on acupuncture, I've tried every herbal medicine there is.' (GF; P5)

Clinicians were sometimes reluctant to discuss alternatives such as sleep hygiene because they thought the patient might interpret such advice as not taking their sleep difficulties seriously. Because so many patients had tried alternatives before consulting, there was an assumption that they expected a 'medical' solution from their doctor and appeared predisposed against alternative suggestions. However, 'medical' solutions sometimes included requests for complementary therapies such as hypnosis and acupuncture.

Alternatives to prescribing had been used to varying degrees by practitioners but there was an underlying concern that non-drug treatments would prove more time consuming. Using alternatives was easier if the practitioner already knew that the patient preferred not to have prescriptions, or if they could identify an alternative that would be able to help. Referral to a counsellor or psychologist was rarely, if ever, considered as an option.

Attitudes to sleep problems. Practitioners' attitudes derived from practice context, patient circumstances, and personal resources, with a greater perceived pressure to prescribe in areas with high levels of deprivation, social problems, or drug abuse. Clinicians often found consultations for sleep problems difficult because although they were reluctant to prescribe, they had few other options and felt pressure to accede to the request for a prescription:

'In my practice we deal with quite a lot of heroin addicts and also the general practice is in a very deprived area so many of my patients will already have tried illicit benzos ... when they have run out of those or when they think they can get them more easily from a doctor they will come to see them.' (G2; C3)

'They might need it if they were abused as a child or if they are depressed or distressed or they might need to go to Citizens Advice [Bureau]²⁴ if they are worrying because they haven't got enough money if their house is about to be repossessed but not for the actual sleep problem.' (G2; C3)

'... it fills me with dread because I don't think I'm going to reach a successful outcome, that's how it makes me feel. I find them difficult consultations, because what I sense the patient wants is tablets, but what I and we've all been in theory of medicine we know that is not the right answer.' (G1; C5)

Patient attitudes also influenced clinical management and were often deeply embedded. Patients' priorities for relief of sleep problems overrode their fears of medication and sometimes differed from their doctors' priorities. Expectations were influenced by previous experience of having received a prescription for a hypnotic. For example, patients expected drugs to 'work' and were surprised when they did not. Conversely, when a sleep hygiene management approach 'worked', they were reluctant to attribute the improved sleep to it. Many patients wanted options for management and others valued self-reliance and self-management:

'... I'm a 74-year-old lady and I'm not worried if I did become addicted, as far as I'm concerned I want to have quality of life.' (GH; P1)

'No, my GP continued to prescribe even though his locum won't. No, I'm not blaming the GP.' (GA; P2)

'It would be nice to have options and to be able to discuss it, but I don't think that the GPs have the options open to them have they? So they can't pass it on.' (GE; P2)

'I want to cope with myself in every way; I'm not the sort of person that relies on other people ... I don't want them to feel, "Oh glory, have we got to deal with her again?"' (GJ; P1)

Improving consultations for sleep problems

Practitioners described approaches for improving the patient experience, specifically, a positive attitude to sleep problems, an acceptance that this was a legitimate presentation, and maintaining awareness of sleep problems as part of physical or psychological problems. A detailed assessment was considered essential and practitioners saw the potential benefits to comorbid conditions of treating insomnia. They saw the need to use time effectively to discuss underlying problems and the insomnia itself. Sleep diaries were adopted by some practitioners as a temporising strategy. Additional resources available to clinicians, as well as appropriate reassurance, were seen as valuable:

'... so no, certainly it's just another problem to be dealt. I don't feel neither any more negative or positive about it.' (G2; C3)

'You have to be aware of the possibility of it being there, you look at the patient's mental history you know what physical problems they might be dealing with already, use open-ended questions ...' (G1; C8)

'I might well ask them what they were hoping would come of the consultation, because I think sometimes we can assume that when a patient comes in and sits down and says they've got a symptom we can assume that they are wanting a prescription and often that is not what they want. I would quite likely ask them what their reason for coming, what they are hoping they get from the consultation.' (G2; C3)

'... Patients presenting with other problems, such as recently retired or multiple minor symptoms, if you get the sleep sorted out the other problems over time will sort themselves out.' (G1; C3)

'... if you are going to do it properly you've got to talk to them in some depth about the sleep problem, it's going to take you some time and you are going to have to get them back again.' (G1; C6)

'Sometimes actually they just need reassurance. It's alright you don't have to have 7/8 hours sleep or that it's alright you are going through a bad spell now and it's not going to last forever. So sometimes just reassurance.' (G2; C3)

To many patients it appeared that clinicians minimised sleep problems or misattributed symptoms as being due to age. Patients were sometimes faced with therapeutic nihilism. Taking insomnia seriously, avoiding false explanations, offering options, and addressing the problem of sleeplessness were key to improving patients' experiences:

'Not sleeping properly is not taken seriously in the scale of things, okay so if you've got a heart condition, or you've got cancer that is serious and the doctor will give you 10 minutes; you go tell him you can't sleep and he'll give you half a minute.' (G1; P2)

'Well it started when I reached 50 but it would seem once you turn 70 they breath a sigh of

relief and say, "Age-related".' (GA; P2)

'He didn't ask me lots of questions, I just told him I was having problems sleeping, is there anything you can do; he said, "I can prescribe you tablets but the tablets are addictive"; that's all, he never went through anything with me.' (GE; P3)

'Well the first thing he said was, "Are you worried about anything?". I said "No"; he said, "Do you have money worries, marital worries? No worries?". NO. The only worry I had was the fact that I couldn't sleep.' (GA; P3)

Adding value. Patients valued clinicians' empathy, listening, time given, and offer of explanations for treatment options. Providing information or a sleep diary without explanation was not seen as useful by patients or practitioners. Continuity of care, a flexibility of approach, and a consistent or common approach within a practice were also found helpful.

'I'd like them to be empathic and listen.' (GH; P4)

'A little bit more time to discuss things with you to get to the root of the problem. It's alright saying to you, "What do you think the problem [is]?". You know what the problem is because that is why you are there.' (GF; P3)

'I found her to be very helpful, she discussed everything with me.' (GD; P3)

'... I want to see the first doctor again because he knows what's wrong with me he can identify the problems and I don't have to keep explaining to everybody all the time. You don't want to.' (GG; P6)

Discouraging unnecessary prescriptions/encouraging alternatives. Strategies that encouraged alternatives to prescribing varied from systematised approaches to more open holistic ones. There was a general consensus that if the underlying problems were of a sensitive nature it might take more than one visit to open the dialogue with the patient. Whereas prescribers (nurses and doctors) had similar knowledge regarding the use of drugs, they held differing knowledge and preferences on alternative strategies to promote sleep. Clinicians described the importance of managing expectations, changing perceptions about sleep and its treatment, and confronting requests for drugs:

'I think sometimes people are advised to come

aren't they; they have been given this expectation and when they fail to meet it, either because they are ageing or someone else has said you should be doing this, they come to get clarification.' (G3; C4)

'... if you are going to do it properly you've got to talk to them in some depth about their sleep problem, it's going to take you some time and you're going to have to get them back again. So you are creating a lot more work for yourself ...' (G1; C6)

'If they expect sleeping tablets, they come in asking for sleeping tablets, part of the consultation is going to have to be dealing with that if that is not an appropriate prescription.' (G2; C2)

Reducing prescribing in patients who are already on hypnotics. Patients were often encouraged to come off sleeping tablets by negative publicity or reinforcement of their lack of effect:

'I was first prescribed temazepam years ago and then there was that big hoo-ha in the paper about people taking them so I rang the NHS Helpline number for that and they said, "Oh well give us your doctor's name, we want to speak to them to tell them they shouldn't be prescribing them". I got the horrors about that and I thought, "No I don't want to really do that", and I came off them myself.' (GK; P2)

'But it wasn't really helping me, I was putting this drug into my body and it's not doing the trick anymore. So I either need to increase the drug or stop it, so I stopped it ...' (GK; P1)

Some prescribers were actively trying to reduce hypnotic prescribing, stimulated by peer pressure and professional guilt about poor practice. Successful approaches were based on a coordinated (whole-practice) approach agreed by all clinicians. GPs invested time and an ongoing interest in the patient, often entering into an informal contract in partnership with the patient to support them in a reduction programme. This was tempered by conflicting priorities of time or other clinical priorities:

'With the current feeling about the Z drugs should I say you feel bad if you've got patients on them long term rather than bad about getting them off it ...' (G3; C6)

'If there is a practice policy with regard this and

everyone is saying the same thing, then it is far more likely to be more successful.' (G3; C4)

'I think it works if the patient feels they are in control of the sort of dose reduction. So I do give them lots of reassurance that I am not going to withdraw the medication quickly and that we'll do it at a pace they are comfortable with.' (G2; C3)

'They've got to want to do it and you've got to spend a lot of time following them up and keeping them happy.' (G3; C5)

'If you are running behind and you've still got to get through their chronic disease management as well as their bad knee that they've actually come in with, then temazepam is not high on the agenda unfortunately.' (G2; C2)

Practitioners thought that reducing hypnotic prescribing was aided by the availability and belief in effectiveness of alternative approaches. Patients described positive health benefits where they had been able to withdraw from long-term medication:

'I think we are, it's just that patients are more receptive to sleep hygiene-type interventions and CBT [cognitive behavioural therapy]-type of interventions having gone down the more investigative approach to sleep.' (G2; C5)

DISCUSSION

Summary of main findings

The findings of this study provide insights into improving patients' experiences in consultations for sleep problems.

Patients felt they needed to convince doctors and nurse prescribers that their sleep difficulties were serious; many had attempted to resolve the problem themselves, often consulting as a last resort. Patients talked about the importance of being shown understanding, listened to, and taken seriously. They tended to describe sleep problems in terms of the impact that they were having on their lives, whereas clinicians tended to focus on underlying causes of insomnia rather than addressing sleeplessness or its consequences.

By the time patients consulted, what was initially construed as a lifestyle problem had become expressed in medical terms, with the expectation of a hypnotic prescription by some, but not all, patients and clinicians. Alternatives to sleeping tablets that patients had tried appeared to work at first but these effects 'wore off'. This led some service users, from their limited experience of self-help methods, to

assume that non-drug treatments would not have lasting effects on their quality of sleep.

Clinicians also felt that some patients might not take non-drug treatments seriously. Clinicians expected patients to be resistant to stopping drugs they were already taking or reluctant to explore alternatives, whereas patients, often deriving little benefit from drugs, were open to alternatives.

Strengths and limitations of the study

The study included a range of clinicians and service users who had experienced consultations for sleep problems within the previous 6 months. They were purposively selected on the basis of their interest in sleep and wish to improve consultations for sleep problems; their views may have reflected this interest. Although limited by problems of recall, contributions were made relevant by recent exposure to consultations for sleep problems. Patients had presented recently and were more likely to have tried a range of non-prescription methods that had not solved their problem. Patients or clinicians who were less interested in this topic may have had different views, but the range of views expressed reflects those concerned to engage with improving management of sleep problems.

Comparison with existing literature

There is a burgeoning literature on the seriousness of sleep problems in terms of duration and chronicity,^{24–26} impact on quality of life, work or social functioning,²⁷ disability,²⁸ and as a risk factor for physical⁷ or mental health conditions.⁶ Patients and practitioners recognise sleep problems to be a response to social adversity.²⁹ Despite this, patients often turn to primary care as a last resort, having already tried self-help¹⁸ unsuccessfully; and when they do, they feel they need to convince practitioners of the seriousness and impact of their insomnia. Other studies have shown that by the time they consult some patients expect hypnotic drugs.³⁰ An empathic, listening, caring approach, as well as technical skills is needed in this, as with many other areas of practice.³¹

Barriers to recognition and treatment of insomnia include inadequate training, lack of time, doubts that sleep problems are important, poor knowledge of treatment options, and uncertainty about evidence.³² Lack of awareness,³³ knowledge, and confidence in managing sleep problems³⁴ are often related to deficiencies in training;³⁵ many practitioners do not appreciate that treatment of insomnia with cognitive behavioural techniques leads to improved outcomes for comorbid disorders as well as sleep itself.³⁶

The case for reducing the inappropriate use of hypnotics is compelling,³⁷ but there are significant

obstacles to using non-pharmacological therapies. Patients often believe that hypnotics are more effective and safer than do doctors,³⁸ and GPs have an unfounded preference for newer hypnotics,¹⁵ encouraging their use.

Practitioners often assume that their patients expect drug treatment¹⁷ even when patients might prefer self-care, just as doctors overestimated patients' expectations of antibiotics for sore throat;³⁹ such misunderstandings⁴⁰ are an important barrier to non-drug options and could be obviated by making expectations explicit.⁴¹

Implications for clinical practice and future research

Practitioners should empathise, listen, elicit patients' beliefs and expectations, and improve their assessments of sleep problems. They need to offer a greater range of treatments including cognitive behavioural therapy, tailor their approach to individual patient need, and explain the effectiveness and drawbacks of different approaches. Suitable resources will be needed and will require modelling, testing, and educational support for their implementation.

Education should incorporate an understanding of the process by which patients decide to seek help, the importance of the clinician's role, what information is important for a shared formulation of the problem, and how to negotiate strategies for resolving the problem. Clinicians need to refer more complex cases as well as to signpost patients to appropriate outside social agencies.

Evaluations of interventions to improve management of insomnia in primary care need to take into account conflicting expectations of therapy; that is, whether or not patients expect a prescription for hypnotics or an alternative, and whether they are disappointed with the outcome or not.

Clinicians and patients wish to improve primary care for insomnia. Relevant education and resources, such as better assessment methods, patient information, and treatment choices, especially non-drug options, appropriate for primary care consultations are needed.

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Ethics committee

Ethical approval was obtained from the NHS Research Ethics Service (07/H0407/59) and the University of Lincoln.

Competing interests

The authors have stated that there are none.

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Appendix 1. Clinician focus group schedule: prescribing professionals' experiences (GPs and nurse prescribers) of being consulted by patients for sleeping difficulties.

- ▶ Q1 How do you approach management of sleep problems?
- ▶ Q2 What do you feel makes patients decide to visit the doctor about it?
Prompts
 - Health beliefs
 - Self-help tried
 - Impact on lifestyle
 - Work
 - Relationships
 - Safety
 - Feelings
 - Other people (could be family or pharmacy, etc)
 - Expectations
- ▶ Q3 How do you respond when the issue of sleeping problems arises?
Prompts
 - Feelings
 - Actions
- ▶ Q4 What causes of sleep problems do you commonly consider in your sleep consultations?
Prompts
 - What strategies do you use to an underlying cause?
- ▶ Q5 What is your approach to assessment with the patient?
- ▶ Q6 What treatment options do you discuss?
Prompts
 - Drugs
 - Sleep hygiene
 - Meditation
 - Hot milk, baths
 - Going to bed early, etc
 - Priorities
- ▶ Q7 What makes you settle on that option?
Prompts
 - Experiences in the past
 - Feelings
- ▶ Q8 What are the issues for you when reviewing patients who have been on long-term hypnotics?
Prompts
 - Feelings
- ▶ Q9 How do you feel about advising patients to come off, and what strategies do you use or have you heard of?

Appendix 2. Patient focus group schedule: patients' experiences of consulting a GP or nurse prescriber for sleeping difficulties.

- ▶ Q1 Can you tell the group a little bit about your sleeping difficulty?
- ▶ Q2 What made you decide to visit the doctor about it?
 - Prompts
 - Health beliefs
 - Self-help
 - Impact on lifestyle
 - Work
 - Relationships
 - Safety
 - Feelings
 - Other people (could be family or pharmacy, etc)
 - Expectations
- ▶ Q3 Was the insomnia/not sleeping the only thing that you went to see your doctor about on that occasion?
 - Prompts
 - How did you get to talking about the insomnia?
- ▶ Q4 What sort of questions did the doctor ask to understand your problem?
- ▶ Q5 What treatment options did you discuss?
 - Prompts
 - Drugs
 - Sleep hygiene
 - Meditation
 - Hot milk
 - Baths
 - Going to bed early, etc
- ▶ Q6 What made you settle on the option that you did?
 - Prompts
 - Experiences in the past
 - Wanted the same
 - Wanted different
 - Feelings
- ▶ Q7 What did you think/feel about your consultation?
 - Prompts
 - Feelings
- ▶ Q8 If you had the consultation again would you like to change anything?

Appendix 3. Coding for patient focus groups.

G = Group (A to K for patient groups). P = Patient.

Category: Patients' reasons for consulting with sleep difficulties

Theme: Significance

► Subtheme: Seriousness

'I said to my doctor recently, "When I die ... I don't want breast cancer on my death certificate, I don't want emphysema, I want insomnia because I am sure that's at the root of all my problems".' (GE; P2)

► Subtheme: Gravitas

'I'm not so bad now but some days I'm really shaky so the doctor can see I'm a nervous wreck.' (GH; P5)

► Subtheme: Impact

'I was having marriage problems because this thing of not sleeping so I went for help really to help me to sleep ...' (GF; P5)

► Subtheme: Justification

'Take for instance Friday night, I went to bed at 10.30 pm; by 11.15 pm I was wide awake, I went back to bed at 3.30 pm then I didn't really want to go to bed, but I do know that if I don't go to sleep I am going to make myself ill with it.' (GC; P2)

Theme: Causation

► Subtheme: Physical

'I wasn't actually working and therefore wasn't expending the energy.' (GK; P1)

► Subtheme: Mental health

'I think a lot of it is because I'm so tired, that is what causes the depression.' (GF; P4)

► Subtheme: Psychosocial

'I will stay awake until I hear him come home ...' (GI; P1)

► Subtheme: Environmental

'I feel there is something in the environment causing this and I asked around my GP and all sorts of specialists, but none of them seem to have met anyone with this particular problem.' (GB; P2)

Theme: Triggers

► Subtheme: Life events

'Where we had been living was in a stressful situation, it was a middle flat, the neighbours were drug addicts and this caused a lot of problems for us. When we moved out, we sort of had a kind of strange withdrawal symptoms, in that the noise was no longer there but still the sleeplessness was a problem.' (GK; P1)

► Subtheme: Medicalisation

'I always think that if it was something I had on my mind I would be aware of that, and I probably wouldn't be going to a doctor to have it sorted I would address it myself, so I always think that's a very bizarre question to ask because if you know there is something on your mind you know what the problem is don't you really.' (GA; P2)

Appendix 3. Coding for patient focus groups...continued.

Category: Patient expectations

Theme: Self-help

- ▶ *'I've read articles where it says you should probably have a hot bath, do this relaxation therapy, listen to relaxing music, I've tried anything I've read about on getting a good night's sleep.'* (GA; P2)
- ▶ *'There was nothing really they could advise, if we'd tried [a sleep aid like] Nytol, the milky drinks at night, going to bed at a certain time and getting up a certain time all that sort of thing, that's about all they discussed, and we'd already tried those.'* (GF; P5)

Theme: Wants

- ▶ *'You are hoping for some lovely panacea tablet or medicine when you go in there and think "Well I've got an appointment they are bound to give me a bit of help".'* (GD; P2)
- ▶ *'The only thing I haven't gone onto is sleeping tablets, I won't go onto sleeping tablets.'* (GI; P2)
- ▶ *'... not just give me a sleeping tablet, but give me some positive feedback that has worked for other people.'* (GD; P3)

Theme: Resistance

- ▶ *'My doctor took a lot of persuading to put me back on them [temazepam]. I said "Look at my age ...what the hell does it matter I've been addicted for 20 years, I might die tomorrow" ... so, so he let me have them.'* (GE; P2)
- ▶ *'The problem is when you try something and it works after a certain amount of time it doesn't work and you need something stronger. You can understand why doctors won't prescribe them — but what's the answer?'* (GF; P5)
- ▶ *'I said I've sleep problems and had it for so long and was thrown some sleeping tablets the next time I went I said I can't keep taking these.'* (GH; P4)

Appendix 3. Coding for patient focus groups...continued.

Category: Influences on sleep management

Theme: Drug prescribing

► Subtheme: Quick fix

'... but we go to the doctors and we already know what's wrong with us and we already know what we want prescribing.' (GK; P2)

► Subtheme: Empowerment

'They know that I am a sensible sort of person with a sensible sort of attitude; they continue with the prescription and I continue using it when I need to and that suits me fine.' (GI; P4)

► Subtheme: Choice

'Certain drugs don't work for me. Zopiclone I've had, but they still insist on trying to prescribe me with it rather than give me another drug like the more powerful drugs, benzodiazepines. They are very reluctant obviously because of the overdose risk etcetera, but they are the only ones that work for me.' (GA; P2)

► Subtheme: Fall-back

'I'm obviously addicted to them; I don't want to come off them straight away. I'm stock-piling and every time I go I get more tablets, because I need to know if he stops them I've got some in reserve for emergencies.' (GH; P5)

► Subtheme: Fear of side-effects or lack of effect

'I was fed up with not being able to sleep, and I was tired of trying to sleep and doing all different things to try to sleep and I thought if I go there perhaps he can give me something to help me make me sleep but when he said that the tablets were addictive I didn't want to take the tablets. So I went another avenue I went to the hypnotist.' (GE; P3)

'I don't want to get addicted to sleep tablets so I won't keep going back.' (GF; P4)

'I didn't want to rely on a tablet that was going to become addictive to me, I didn't want to be taking a tablet for the rest of my life you know to sleep, and who is going to say it's going to work.' (GE; P3)

► Subtheme: Unhelpful/counterproductive

'I never sleep for any length time when I have the sleeping tablets.' (GD; P5)

'Temazepam for me was the worst thing ever ... I hated it. It was the only reason I went but I went back twice after that to say don't give me these ... It was not a good idea.' (GI; P2)

'... sleeping tablets are no answer and they make me dozy all day long.' (GA; P2)

'I had sleeping pills on and off, I take 40 mg temazepam now and I know they are addictive and I have been on them this time for 15 years, but I think at my time of life what the hell, does it matter. I sleep, the best sleep I ever have is two hours, never more than that. Recently I've been awake all night for two nights and I took 50 mg of temazepam at 7.30 pm, and went to bed and thought I really need to get some sleep.' (GE; P2)

► Subtheme: Misuse

'Recently my doctor said I'm going to give something that what you'd call a "Mickey Finn" knockout drops; he said one spoonful and 2 hours later I took another and another. The next night I drank two-thirds of the bottle.' (GE; P2)

Theme: Alternatives to prescribed drugs

► Subtheme: Exercise

'My wife says go out and play more golf or whatever.' (GA; P2)

► Subtheme: Relaxation

'We all had to lie on the floor and you know from the tip of your toes to your head you are completely relaxed ... and some of these people were practically asleep but it just had no effect on me whatsoever. I think I must be just one of those people where these kinds of things don't work.' (GA; P3)

► Subtheme: Over-the-counter remedies

'From the chemists, like Sleepaze all those sorts of things and they don't do anything. I'm a great reader of anything, and if anyone suggests anything I'll go and buy that book.' (GE; P2)

Appendix 3. Coding for patient focus groups...continued.

► Subtheme: Herbal remedies

'What really annoys me and you could punch people for saying this is, have you tried lavender — ooohhh.' (GH; P4)

'... they gave me this stuff like this witches' brew, it was vile I've never tasted anything like it, like tree bark all bits and bobs in it, boiled it for about 20 minutes strained it and drank it, you have a glass of water or orange juice at the side to take straight after, whoosh take it down, you have this horrible vile taste, but it didn't do me any good. I think again not being detrimental to anybody else who has tried, but I think it's mind over matter ...' (GD; P2)

'I have a sleep teabag, these teabags you get at a health shop, I have one every night, I take one to bed with me, I've got herbal Nytol, but it still doesn't make a difference.' (GD; P5)

► Subtheme: Complementary therapies

'Anything I have done I've done off my own bat — I've gone for massages.' (GC; P2)

'I have spent £500 on acupuncture I've tried every herbal medicine there is.' (GF; P5)

'Yes acupuncture, but that was a long time ago, and spiritual healers, several spiritual healers, and recently I've been seeing a woman who does reiki.' (GE; P2)

► Subtheme: Cognitive behavioural therapy

'Cognitive behavioural therapy where the theory behind this ... my children, my daughter bought me a book for Christmas (an American book), about that thick [gestures], where the whole thing behind it is whatever your problem it is cured by changing your thoughts [giggle]. It's a good idea.' (GA; P2)

► Subtheme: Miscellaneous

'I can make you laugh more than that I was told to put a dream catcher above my bed — it didn't do any good.' (GH; P3)

► Subtheme: Alternatives ineffective

'I've done all the relaxation things I've had the tapes, I've taken Horlicks I've gone to the health shops but the only thing that helps me are, they are not Mogadons they are little tiny white things.' (GA; P3)

'I do everything right you know, to get to sleep, you wind down, I never drink anything, tea or coffee [other than herbal] after 3.00 in the afternoon. I drink very little of it anyway because I have detox stuff and I've done sleep hygiene with lots of people I visit. But it doesn't make a blind bit of difference.' (G2; P5)

'... you have tried a couple of natural health things that didn't work, but you are not sure whether that is because you didn't want them to work, again a psychological thing in the background, you wanted the security of what you know does work.' (GJ; P2)

Theme: Attitudes to dealing with sleep difficulties

► Subtheme: Priorities

'... I'm a 74-year-old lady and I'm not worried if I did become addicted, as far as I'm concerned I want to have quality of life.' (GH; P1)

► Subtheme: Previous experience

'No, my GP continued to prescribe even though his locum won't. No, I'm not blaming the GP.' (GA; P2)

► Subtheme: Options

'It would be nice to have options and to be able to discuss it, but I don't think that the GPs have the options open to them, have they? So they can't pass it on.' (GE; P2)

► Subtheme: Self reliance

'I want to cope with myself in every way I'm not the sort of person that relies on other people ... I don't want them to feel, "Oh glory, have we got to deal with her again".' (GJ; P1)

Appendix 3. Coding for patient focus groups...continued.

Category: Consulting for sleep problems

Theme: Improving patients' experiences

► Subtheme: Minimisation — taking insomnia seriously

'... and they've all pooh poohed it. They've all made me feel really silly and that small as though I've made it up.' (GH; P4)

'Not sleeping properly is not taken seriously in the scale of things, okay so if you've got a heart condition, or you've got cancer that is serious and the doctor will give you 10 minutes; you go tell him you can't sleep and he'll give you half a minute.' (GI; P2)

► Subtheme: Misattribution — avoiding false explanations

'Well it started when I reached 50 but it would seem once you turn 70 they breath a sigh of relief and say "Age-related".' (GA; P2)

► Subtheme: Therapeutic nihilism — offering options

'Well we didn't [discuss treatment options] ... there was nothing really they could advise, if we'd tried [a sleep aid like] Nytol, the milky drinks at night, going to bed at a certain time and getting up a certain time all that sort of thing, that's about all they discussed, and we'd already tried those.' (GF; P5)

'He didn't ask me lots of questions, I just told him I was having problems sleeping, is there anything you can do, he said "I can prescribe you tablets but the tablets are addictive", that's all he never went through anything with me.' (GE; P3)

► Subtheme: Addressing the problem

'Well the first thing he said was, "Are you worried about anything?". I said "No"; he said "Do you have money worries, marital worries? No worries?". NO. The only worry I had was the fact that I couldn't sleep.' (GA; P3)

Theme: Adding value

► Subtheme: Empathy

'I felt it didn't matter to them because they were sleeping.' (GK; P2)

'I'd like them to be empathic and listen.' (GH; P4)

► Subtheme: Listening

'She actually sat there and listened to what I had to say.' (GF; P4)

► Subtheme: Time

'A little bit more time to discuss things with you to get to the root of the problem. It's alright saying to you, "What do you think the problem [is]?". You know what the problem is because that is why you are there.' (GF; P3)

► Subtheme: Explanation

'I found her to be very helpful, she discussed everything with me.' (GD; P3)

► Subtheme: Continuity

'... I want to see the first doctor again because he knows what's wrong with me he can identify the problems and I don't have to keep explaining to everybody all the time. You don't want to.' (GG; P6)

'But when I went back to see this GP his 3 months was up and he was away somewhere else. I then saw another GP and had to explain it all and very grudgingly she did give me another 14 days and I haven't had any since then.' (GA; P3)

► Subtheme: Options

'It would be nice to have options and to be able to discuss it, but I don't think the GPs have the options open to them, have they? So they can't pass it on.' (GE; P2)

'... it would still be nice for them to say "We don't want you to take the tablets long term so would you like to try something else if you find sleep is still difficult for you?". Yes, and it would be nice to know you've got something else other than tablets.' (GD; P3)

► Subtheme: Flexibility

'It's either drugs or something else and I think the key would be a bit of both.' (GA; P2)

► Subtheme: Common approach

'There are 4, 5, 6 doctors ... they are all different and they don't approach things in the same way, I feel they need a common approach to certain illnesses.' (GH; P2)

Theme: Reducing drug prescribing in patients who are already on hypnotics

► Sub-theme: Negative publicity

'I was first prescribed temazepam years ago and then there was that big hoo-ha in the paper about people taking them so I rang the NHS Helpline number for that and they said "Oh well give us your doctor's name, we want to speak to them to tell them they shouldn't be prescribing them". I got the horrors about that and I thought "no I don't want to really do that", and I came off them myself.' (GK; P2)

► Subtheme: Ineffective

'But it wasn't really helping me, I was putting this drug into my body and it's not doing the trick anymore. So I either need to increase the drug or stop it, so I stopped it ...' (GK; P1)

Appendix 4. Coding for clinician focus groups.

G = Group (1 to 3 for clinician groups). C = Clinician.

Category: Clinicians' explanations for patients consulting with sleep difficulties

Theme: Significance

► Subtheme: Seriousness

'I sometimes feel it is used by patients as a qualifier you know if they are having a discussion with you about their knee and they don't feel you are taking it serious enough, they will throw in the fact that it is keeping them awake — as a sort of extra bit of punishment really.' (G3; C4)

► Subtheme: Impact

'Can't carry on with work, they are too exhausted, a relationship problem, lots of things.' (G1; C2)

► Subtheme: Justification

'I think sometimes it is also a more socially acceptable presentation because what they are really saying is that my quality of life has gone downhill and that there are a lot of other issues that come to the surface and are packaged as a sleep problem' (G3; C5)

► Subtheme: Reassurance

'The only other thing that I would say is that sometimes actually they just need reassurance, it's alright, you don't have to have 7 or 8 hours' sleep ...' (G2; C3)

Theme: Causation

► Subtheme: Physical

'... breathing problems, asthma that sort of thing.' (G3; C7)

► Subtheme: Mental health

'Something underlying, stress, depression, anxiety ...' (G1; C5)

► Subtheme: Psychosocial

'We get quite a lot of social problems as well whereas they cannot sleep because my neighbour is noisy ...' (G1; C3)

► Subtheme: Environmental

'Sometimes they don't, sometimes you find that they are just cold in bed, or that they have to keep getting up to go to the loo and that hasn't occurred to them that's why they are not sleeping.' (G2; P3)

► Subtheme: Multiple causes

'Very few for pure insomnia ...' (G3; C5)

Theme: Triggers

► Subtheme: Life events

'Frustration, usually they have had some problem which has been going on for a while, something causes them to get to the end of their tether, some life event.' (G3; C7)

► Subtheme: Medicalisation

'... various tales some of which are quite detailed and quite complicated for us to understand.' (G1; C6)

► Subtheme: Social networks

'Work mates or family might sometimes have suggested they go and see the doctor to get it sorted out.' (G2; C3)

Appendix 4. Coding for clinician focus groups...continued.

Category: Clinician expectations in the consultation

Theme: Self-help

'I always find the exercise one quite good because they usually had twiggled on and often didn't drink too much tea or coffee, but the exercise one was the one you could get most of them on.' (G3; C8)

Theme: Wants

'It's actually quite staggering the amount of people who come asking for sleeping tablets which they know are addictive and they still want the sleeping tablets.' (G1; C3)

'Previous experience, if we know the patient is anti-medication then we obviously go through the other options.' (G3; C9)

Theme: Resistance

'... because you knew you had a bit of a battle on your hands to not prescribe sleeping tablets and get a happy patient walking out the door.' (G3; C7)

Theme: Extent of sleep problems

'... [the Resources for Effective Sleep Treatment (REST) Project] makes you ask more about sleep problems so you find generally more sleep problems than you ever knew existed really or you suspected were there.' (G1; C5)

Category: Influences on sleep management

Theme: Drug prescribing

► Subtheme: Quick fix

'... if someone came in and said I couldn't sleep, I thought "Great take this ...".' (G3; C4)

► Subtheme: Justified

'... often I would have tried to persuade them to try these various different things but of course they would say, "Tried that doctor, tried that doctor, doesn't work".' (G2; C3)

► Subtheme: Legitimate

'I get a couple of patients who ask for them when they go away, work away ...'

► Subtheme: Appropriate

'... no doubt you see people who have recently been bereaved or have lost their job and they are looking for a short-term solution and I think that we would probably deal with that quite differently to someone who comes and says they have never slept very well, it's been a long-term problem.' (G2; C3)

Theme: Alternatives to prescribed drugs

'Life style, do they do any sort of exercise, avoiding alcohol and caffeine and things like that ...' (G1; C4)

'... and for them to think you are taking their problem really seriously and trying to help them but not give them what they really came for which was a sleeping tablet.' (G3; C7)

'But I think what we are saying is that counselling would only be considered for a very small minority of patients who came with a presentation of insomnia, it would only be appropriate for a very very few of them.' (G2; C3)

Theme: Attitudes to dealing with sleep difficulties

► Subtheme: Practice context

'In my practice we deal with quite a lot of heroin addicts and also the general practice is in a very deprived area so many of my patients will already have tried illicit benzos ... when they have run out of those or when they think they can get them more easily from a doctor they will come see them.' (G2; C3)

► Subtheme: Patient circumstances

'They might need it if they were abused as a child or if they are depressed or distressed or they might need to go to Citizens Advice [Bureau]²⁴ if they are worrying because they haven't got enough money or their house is about to be repossessed but not for the actual sleep problem.' (G2; C3)

'... and then they ring up and say, "I can't sleep, I'm so much better when I have them, can I just have a course, I'll use them very sensibly and I'll not use them every day and I promise that I'll come off them".' (G1; P3)

'Patients are on so many medications now that often getting rid of one of them is seen as a benefit for them.' (G2; C2)

► Subtheme: Personal resources

'... it fills me with dread because I don't think I'm going to reach a successful outcome, that's how it makes me feel. I find them difficult consultations, because what I sense the patient wants is tablets, but what I and we've all been in theory of medicine we know that is not the right answer.' (G1; C5)

Appendix 4. Coding for clinician focus groups...continued.

Category: Consulting for sleep problems

Theme: Improving patients' experiences

► Subtheme: Acceptance

'... so no, certainly it's just another problem to be dealt. I don't feel neither any more negative or positive about it.' (G2; C3)

► Subtheme: Awareness

'You have to be aware of the possibility of it being there, you look at the patient's mental history you know what physical problems they might be dealing with already, use open-ended questions ...' (G1; C8)

► Subtheme: Assessment

'I think I would try to identify what they mean by sleep problem, what is the patient's idea as to why they are coming to us with this problem what ... they feel is a normal sleep pattern, what they feel is different for them, and why at this particularly time they have come to us with their ... problem.' (G2; C2)

'I might well ask them what they were hoping would come of the consultation, because I think sometimes we can assume that when a patient comes in and sits down and says they've got a symptom we can assume that they are wanting a prescription and often that is not what they want. I would quite likely ask them what their reason for coming, what they are hoping they get from the consultation.' (G2; C3)

'Well I try to take a fuller history as I can take. I will try and elicit whether (a) there really is a sleep problem because sometimes they perceive if they are not sleeping 8 hours a night then that's wrong, so first of all is there a sleep problem and (b) if I can work out what the cause of the sleep problem is: pain, or an uncomfortable bed or a husband that snores then try and deal with that issue.' (G2; C3)

► Subtheme: Benefit to comorbidity

'... Patients presenting with other problems, such as recently retired or multiple minor symptoms, if you get the sleep sorted out the other problems over time will sort themselves out.' (G1; C3)

► Subtheme: Use of time

'... if you are going to do it properly you've got to talk to them in some depth about the sleep problem, it's going to take you some time and you are going to have to get them back again.' (G1; C6)

'Have I got time for this? If it's their main problem then it's not bad, but if it's following a secondary problem quite often ... emotional disorders ... I will deal briefly with it and give them something to go away but [say] I want you to come back. It's quite a big topic to cover in a short period of time.' (G1; C2)

'Giving a sleep diary as well is an avoidance tactic for prescribing in one respect which it is hoped will allow us to identify some of the issues.' (G1; C6)

► Subtheme: Resources

'I'm very positive about it having all this information.' (G1; C2)

► Subtheme: Reassurance

'Sometimes actually they just need reassurance. It's alright you don't have to have 7/8 hours sleep or that it's alright you are going through a bad spell now and it's not going to last forever. So sometimes just reassurance.' (G2; C3)

Theme: Discouraging unnecessary prescriptions/encouraging alternatives

► Subtheme: Managing expectations

'I think sometimes people are advised to come aren't they; they have been given this expectation and when they fail to meet it, either because they are ageing or someone else has said you should be doing this, they come to get clarification.' (G3; C4)

► Subtheme: Changing perceptions

'... if you are going to do it properly you've got to talk to them in some depth about their sleep problem, it's going to take you some time and you're going to have to get them back again. So you are creating a lot more work for yourself ...' (G1; C6)

► Subtheme: Confrontation

'If they expect sleeping tablets, they come in asking for sleeping tablets, part of the consultation is going to have to be dealing with that if that is not an appropriate prescription.' (G2; C2)

Appendix 4. Coding for clinician focus groups...continued.

Theme: Reducing drug prescribing in patients who are already on hypnotics

► Subtheme: Peer pressure

'With the current feeling about the Z drugs should I say you feel bad if you've got patients on them long term rather than bad about getting them off it ...' (G3; C6)

► Subtheme: Proactive

'I have found that I have never had anyone come to me to review my sleepers ...' (G3; C7)

► Subtheme: Coordinated (whole-practice) policy

'If there is a practice policy with regard this and everyone is saying the same thing, then it is far more likely to be more successful.' (G3; C4)

► Subtheme: Partnership

'I think it works if the patient feels they are in control of the sort of dose reduction. So I do give them lots of reassurance that I am not going to withdraw the medication quickly and that we'll do it at a pace they are comfortable with.' (G2; C3)

► Subtheme: Investing time

'They've got to want to do it and you've got to spend a lot of time following them up and keeping them happy.' (G3; C5)

► Subtheme: Conflicting priorities

'If you are running behind and you've still got to get through their chronic disease management as well as their bad knee that they've actually come in with, then temazepam is not high on the agenda unfortunately.' (G2; C2)

► Subtheme: Belief in effectiveness

'I think we are, it's just that patients are more receptive to sleep hygiene-type interventions and CBT [cognitive behavioural therapy]-type of interventions having gone down the more investigative approach to sleep.' (G2; C5)